

GEORGIA STATE BOARD OF LONG-TERM CARE FACILITY ADMINISTRATORS 237 Coliseum Drive Macon, GA 31217 404-424-9966 (Telephone), www.sos.ga.gov/plb

APPLICATION FOR APPROVAL as a PRECEPTOR for a

NURSING HOME "ADMINISTRATOR-IN-TRAINING" PROGRAM

PLEASE TYPE OR PRINT CLEARLY IN INK. Where the space provided is not sufficient, attach additional sheets.

- Enclose Application Fee of \$75.00 + 10.00 processing fee by check or money order payable to "Georgia State Board of Long-Term Care Facility Administrators". Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. §16-9-20.
- To be approved as a Preceptor, the Applicant must be currently licensed in Georgia, the nursing home administrator of record at an approved site (or have attached the AIT Site Application with this application), employed and working fulltime at the nursing home and have been employed as a licensed nursing home administrator for a minimum of five (5) years with the final (5th) year being in the state of Georgia. Provide proof by submitting Form A or a letter(s) verifying employment for the five (5) years. See Board Rules 393-4-.01 and 393-4-.02.
- Proof of completion of the "Nursing Home Administrator" course through the Georgia Healthcare Association (GHCA) must be submitted. See Board Rule 393-4-.02(4)(c).

 Affidavit of Citizer 	nship and a Secure and ${f V}$	erifiable Docume/	nt must be submitted	I with this Precepto	r approval application.	
NAME:	Last First					
PHYSICAL Last	First		Middle	N	1aiden	
ADDRESS:						
ADDRESS	Street (P.O. Box is not	acceptable)	City	State	Zip Code	
	(****		,			
MAILING ADDRESS:						
	Street	City		State Zip Cod		
*(If you are granted a license, Your physical address is require	, your name, <u>mailing address</u> : red. if different than the mailin					
	•					
HOME PHONE: ()	BU	SINESS PHONE	E: ()	FAX: ()	
EMAIL ADDRESS:						
DATE OF BIRTH:	1 1	*SOCIAL SECLI	RITY #:	/ /		
	/ NTH/DAY/YEAR				 state and federal agencies	
	, = ,, . = ,				C.A. 551 and 20 U.S.C.A.	
		,			tabank (NPDB) and the	
		,	and Protection Data B for license tracking pu	,	r licensing boards, or other	
	PART		R QUALIFICATION			
GEORGIA NHA LICENS	3E #:	IS:	SUANCE DATE:			
DOCL	JMENT FIVE (5) YEARS OF	EXPERIENCE AS	A LICENSED NURSING	G HOME ADMINISTE	RATOR	
From:	To:	Ye	ar(s):	Month(s):	
	INDICATE EACH FACILIT	V WILEDE VOLLLA	AL DDA CTICED AC AA	LADMINICTDATOD.		
	INDICATE EACH FACILIT	Y WHERE YOU HA	VE PRACTICED AS AN	N ADMINISTRATOR:		
 Name of Nursin 	g Home:					
A 1.1						
Address:						
From:	To:	Voor(c)		Month(c):		
From:	10	rear(s)	•	1011111(5)		
2. Name of Nursin	g Home:					
Address:						
From:	To:	Year(s)	:	Month(s): _		
(Use an additional Shee	et if needed)					

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		PART II – PROFESSIONAL BACKGROUND		
	rent s	"Yes" to any of the following questions, attach an explanation, relevat status. For the purpose of the following questions, the terms "license		
Yes	_No	Have you been approved in the past as a Preceptor? If "Yes", please explain [Site, Date/s, etc.]		
Yes	_No	O Do you now hold, or have you ever held a Nursing Home Administration of the section below:	ator's license in another state?	
		License TitleLicense	#	
		State Date Issued	Expiration Date	
		License TitleLicense	#	
		State Date Issued	Expiration Date	
Yes	No	Have you had revoked or suspended or otherwise sanctioned any agency in Georgia or any other state?	license issued to you by any board or	
Yes	No	No Were you denied issuance of or, pursuant to disciplinary proceeding the privilege of taking an examination by any state licensing board'		
Yes	_No	o Have you knowingly failed to renew a license during an investigatio	n of disciplinary action?	
Yes	_No	Have you been subject to disciplinary action or had your membership revoked by a professional organization governing the practice of that profession?		
Yes	_No	To the best of your knowledge, is there any disciplinary action pending against you by any licensing board or professional organization?		
Yes	No	lo Have you ever been arrested?		
		Note : The answer to this question is "Yes" if an arrest or conviction a dismissed or deferred, you pled and completed probation under First have been restored and/or you have received legal advice that the criminal record.	t Offender and/or your civil rights	
Yes	No	lo Are you currently unable to practice with reasonable skill and safety alcohol, drugs, narcotics, chemicals or any other type of material, o condition?		
Yes	_No	ο Have you had any suit filed against you related to the practice of a μ	profession?	
Yes	_No	o Have you ever had your Medicaid and/or Medicare privileges revok	ed or restricted?	
Yes	No	lo Have you ever been convicted of a felony or misdemeanor (other the of guilty or nolo contendere, or entered a plea under a first offender		

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PART III - A.I.T. APPROVED SITE(S)

Please indicate the name of the facility (site) where you will be a preceptor in the first section below. Please indicate any other approved sites for which you have provided services as a preceptor.

*NOTE: If the facility you are the NHA of Record is not already a Board approved training site, please be sure and submit the Application for AIT Training Site Approval.

*AIT SITE - NAME of SITE WHERE YOU ARE	THE NHA of RECOF	RD, and WILL SERVE as the	ne PRECEPTOR:	
ADDRESS:				
Street	City	State	Zip Code	
PHONE: () FAX: (1	*License #:NHAS		
PRIOR AIT APPROVED SITE: O	ther facility where yo		eptor	
NAME:				
TWAWIE.				
ADDRESS:				
Street	City	State	Zip Code	
PHONE: ()	FAX: ()			
PRIOR AIT APPROVED SITE: O	ther facility where yo	u were the licensed prece	eptor_	
NAME:				
ADDDECC.				
ADDRESS:Street	City	State	Zip Code	
- Circos	O.I.y	Claro	<u> </u>	
PHONE: ()	FAX: ()			
DUTI	ES OF PRECEPT	OR:		
Board Rule: 393-402: The preceptor is solel and Rules of the Board, and must attest to such				
The preceptor must ensure that the AIT is not				
detrimental to his or her training, and must ensure that the intern is afforded a broad and comprehensive experience.				
охронопос.				
A monthly report is to be submitted to the Board beginning the month after the starting date of the AIT				
program. If an AIT program begins in the middle of a month, then ONLY submit the first report for the days of				
the month training was completed – Do not overlap months in one report. This report must follow the				
individualized schedule and describe the activities of the month and should be signed and notarized by both the Preceptor and the AIT.				
the recopion and the 7th.				
If AIT does not submit reports showing proper	hours worked, a der	nial will be issued.		
If time off is granted during AIT, it must not affe	ect the completion of	the program and it must	be documented on	
the monthly reports.	<u> </u>	The programme are in the second		
· · · · · · · · · · · · · · · · · · ·				
Is there an individual who is already licensed, or wi	II be applying for an Al	T License to be trained at tl	ne site you are	
applying for with this application to be the Preceptor			•	
NAME:	·			
AIT License #: NHAT, or, app		adv applied):		
All License #. NITA1, or, app	iication number (ii alle	auy applieu)		

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Georgia State Board of Long-Term Care Facility Administrators 237 Coliseum Drive, Macon, GA 31217

Phone: 404-424-9966, <u>www.sos.ga.gov/plb</u>

AFFIDAVIT OF EXPERIENCE - FORM A

- Please type or print legibly
- Complete a form for each employer in order to meet the required nursing home experience for your application.
- Applicant completes Part I ONLY
- Owner/Administrator of the nursing facility or the employer/superior in the chain of command at the home office that operates the licensed nursing facility and/or hospital completes Part II

PART I – APPLICANT				
Applicant's Name				
Name of business or corporation that owns facility:				
Name of facility				
address of facility				
Street	City	State	Zip	
hone number of facility	Position hel	d		
Dates employed - From: To: To:	Month/Year	_		
Description of Responsibilities:				
Affidavit				
, the above Applicant, attest that the above btained in a nursing facility or home office				
	Signature	of Applicant		

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PART II – OWNER/ADMINISTRATOR/EMPLOYER/SUPERIOR

Instructions

	cant's description of experience; s/additional information that will assist the Board in its decision.
Comments	
command at the home of by the Applicant of the elicensed nursing facilities	Owner/Administrator of the nursing facility, or, Employer or Superior in the chain of ffice that operates licensed nursing facilities and/or hospitals, attest that the description provided experience obtained in a nursing facility, home office of a business or corporation that operates as or hospitals, is true and accurate, and I further acknowledge that I may be required to furnish romptly for this application to be processed.
Date	Signature of Nursing Home Administrator/Employer
Subscribed and sworn to	before me this
day of	20
Notary Public	
My Commission Expires	
Notary Seal	

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APPLICANT SIGNATURE & AFFIDAVIT YOU MUST SIGN THIS AFFIDAVIT IN THE PRESENCE OF A NOTARY

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the <u>Georgia State Board of Long-Term Care Facility Administrators</u>, and I agree to abide by these laws and rules, as amended from time to time.

My Commission Expires:		
Notary Public Signature		(Notary Seal)
day of		
Sworn to and subscribed before me this	20	
Signature of Applicant		Date
<u> </u>		at any failure to make full and accurate disclosures may result dof Long-Term Care Facility Administrators and/or criminal
years of age or older Immigration and Na Department of Home copy of your curren number or your I-9	r, or I am a c tionality Ac eland Secur nt immigra 14 number	t, but I am a legal permanent resident of the United States 18 qualified alien or non-immigrant under the Federal et 18 years of age or older with an alien number issued by the rity or other federal immigration agency. Please submit a stion document(s) which includes either your Alien and, if needed, SEVIS number
Secure and Verifiab	ole Docume	ears of age or older. Please submit a copy of your current ent(s) such as driver's license, passport, or other list of acceptable documents on website).
By signing this application, electronic true and accurate pursuant to O.C.G.		erwise, I hereby swear and affirm one of the following to be 1:
rules and regulations of the <u>Georgia S</u> abide by these laws and rules, as ame		of Long-Term Care Facility Administrators, and I agree to time to time.

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